TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
HAIDER SPINE CENTER MEDICAL GROUP

MFDR Tracking Number
M4-17-2489-01

MFDR Date Received
April 18, 2017

Respondent Name
TEXAS MUTUAL INSRUANCE COMPANY

Carrier's Austin Representative
Box Number 54

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "*Claim has been corrected. Changed CPT Code to 99213."

Amount in Dispute: $144.05

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed code 99214 for date 10/3/16. Texas Mutual reviewed the documentation and determined it did not meet the 2016 CPT criteria for that code. Texas Mutual received the bill 11/22/16. (Attachment) Texas Mutual has no record of receiving a request for reconsideration (RFR) from the requestor nor has the requestor provided any evidence in the DWC60 packet that an RFR was submitted. Now, there is a bill in the DWC60 packet that lists code 99213. There is no date in BOX 31. Annotated in bold type at the top is 'CORRECTED CLAIM.' Texas Mutual did not receive this from the requestor but the Division. If Texas Mutual processed this bill TMI would deny payment absent timely bill submission. No payment is due."

Response Submitted by: Texas Mutual insurance Company

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
October 3, 2016	99214 (Changed CPT Code to 99213)	$144.05	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
3. The services in dispute, CPT Code 99214 was reduced/denied by the respondent with the following reason codes:
   - CAC-150 – Payer deems the information submitted does not support this level of service
   - CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
   - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information
   - 890 – Denied per AMA CPT Code description for level of service and/or nature of presenting problems

Issues

1. What services did the requestor bill the insurance carrier for?
2. Did the requestor submit sufficient documentation to support the billing of CPT Code 99214?
3. Is the requestor entitled to reimbursement?

Findings

1. Review of the DWC060 "Table of Disputed Services" indicates that the requestor seeks reimbursement for CPT Code 99214 in the amount of $144.05 rendered on October 3, 2016. The requestor indicated on the "Table of Disputed Services" the following, "Claim has been corrected. Changed CPT Code to 99213," however the requestor failed to identify the following for CPT Code 99213 "Amount Billed", "Amount Paid" and "Amount in Dispute" for this code.

   The Division finds the following for CPT Code 99213:

   28 Texas Administrative Code §133.307(c)(2)(J), requires that the request shall include "a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier . . . and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250." Review of the submitted documentation finds that the requestor has not provided a copy of the medical bill(s) as originally submitted to the insurance carrier and/or as submitted to the insurance carrier for an appeal in accordance with §133.250. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(J).

   28 Texas Administrative Code §133.307(c)(2)(K), requires that the request shall include "a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider . . . or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB." Review of the submitted documentation finds that the request does not include copies of any EOBs for the disputed service. Nor has the requestor provided evidence of insurance carrier receipt of the request for an EOB. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(K).

   28 Texas Administrative Code §133.307(c)(2)(N)(i), requires that the request shall include a position statement including "the requestor's reasoning for why the disputed fees should be paid." Review of the submitted documentation finds that the requestor has not explained the requestor's reasoning for why the disputed fees should be paid. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(N)(i).

   28 Texas Administrative Code §133.307(c)(2)(N)(ii), requires that the request shall include a position statement of the disputed issues including "how the Labor Code and division rules, including fee guidelines, impact the disputed fee issues." Review of the submitted documentation finds that the requestor has not discussed how the Labor Code and division rules, including fee guidelines, impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(N)(ii).

   28 Texas Administrative Code §133.307(c)(2)(N)(iii), requires that the request shall include a position statement of the disputed issues including "how the submitted documentation supports the requestor's position for each disputed fee issue." Review of the submitted documentation finds that the requestor has not discussed how the submitted documentation supports the requestor's position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(N)(iii).

   Texas Labor Code §408.027(a) states that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

   The Division finds that the requestor submitted insufficient documentation to support that the insurance carrier was billed and audited CPT Code 99213. As a result, reimbursement cannot be recommended for this disputed service.

2. Review of the submitted documentation for CPT Code 99214 finds the following:

   28 Texas Administrative Code §133.307(c)(2)(J), requires that the request shall include "a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier . . . and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250." Review of the submitted documentation finds that the requestor has not provided a copy of the medical bill(s) as originally submitted to the insurance carrier and/or as submitted to the insurance carrier for an appeal in accordance with §133.250. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(J).

   28 Texas Administrative Code §133.307(c)(2)(K), requires that the request shall include "a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider . . . or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB." Review of the submitted documentation finds that the request includes a copy of the initial EOB review, however the requestor did not include a copy of the reconsideration EOB and or sufficient evidence of the insurance carrier receipt of the request for an EOB.

The Division finds that the requestor submitted a copy of an EOB dated, 12/19/16 for CPT Code 99214. The insurance carrier denied CPT Code 99214 with denial reduction codes:

- CAC-150 – Payer deems the information submitted does not support this level of service
- CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information
- 890 – Denied per AMA CPT Code description for level of service and/or nature of presenting problems

The requestor did not include a reconsideration EOB and/or sufficient evidence of the insurance carrier's receipt of the request for an EOB. As a result, the Division finds that the requestor submitted insufficient documentation to support the billing of CPT Code 99214. As a result, the requestor is entitled to $0.00 for CPT Code 99214 rendered on October 3, 2016.

3. The Division finds that the requestor is not entitled to reimbursement for CPT Code 99214 rendered on October 3, 2016.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 12, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.